

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN4709	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/08/2012
NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, FT SANDERS			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 HIGHLAND AVE KNOXVILLE, TN 37916		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments During an annual licensure survey and complaint investigation numbers TN28888 and TN28968, completed on February 8, 2012, no deficiencies were cited under 1200-8-6 Standards for Nursing Homes.	N 000			

Division of Health Care Facilities

Douglas S. Ford
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE
N.H.A.

(X6) DATE

2/14/12

STATE FORM

6899

X9TW11

If continuation sheet 1 of 1

FEB 16 2012